TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MICHAEL W. DICKEY, MD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-2617-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this review.

Amount in Dispute: $582.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No other treatment was carried out. No diagnostic testing was administered. This was not an emergency admission as defined by Rule 133.2."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2016	Emergency Room Evaluation and Management	$582.00	$96.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.

6. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. Are the insurance carrier's denial reasons supported?
2. Is an emergency supported?
3. Does the documentation support the service as billed?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment for the services in dispute?
6. Is the requestor entitled to additional reimbursement?

Findings

1. Are the insurance carrier's denial reasons supported?

   The insurance carrier denied disputed services with claim adjustment reason code 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2."

   This denial reason does not, in and of itself, preclude payment; the Texas Workers' Compensation Act, at Labor Code Section 408.021 provides that "an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." The entitlement is not limited to emergency care, and an emergency is not a prerequisite for payment of treatment for a covered injury.

   While medical emergency may be an *exception* to certain other denial reasons, the insurance carrier has not raised any of those denial reasons on the EOBs. Discussing an exception to a denial reason does not raise a material defense by implication. The respondent has not presented any such defenses to the health care provider prior to MFDR — and may not do so now.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Review of the submitted information finds no explanations of benefits with denial reasons supporting an independent basis for denying payment to which the requirement of an emergency would be an exception. The insurance carrier's failure to assert on the explanations of benefits specific denial reasons or defenses relating to the services in dispute during the bill review process—before the request for MFDR—constitutes grounds for the division to find a *waiver* of any such new defenses at Medical Fee Dispute Resolution.

   The division finds the respondent has waived any new denial reasons or defenses not previously raised and is therefore limited to the EOB denial reasons and defenses presented to the requestor during the bill review process—prior to the date MFDR was requested—as listed above.

   Review of the insurance carrier's denial reasons finds that the respondent has failed to establish an independent grounds for denying the bill—and specifically has not raised any defenses to which the existence of an emergency would be relevant as an exception. Consequently, the question of whether an emergency existed is not relevant to payment of this bill. The insurance carrier's denial reasons are thus not supported.

2. Nevertheless, review of the submitted information finds that a medical emergency is supported.

   Rule §133.2(5)(A), defines a medical emergency as:

   > the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   > (i) placing the patient's health or bodily functions in serious jeopardy, or
   > (ii) serious dysfunction of any body organ or part.

   The division notes this rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

   The respondent argues that after examination, the physician record reports that the pain was "chronic," and "moderate," that the ROS was negative, vital signs were normal, and no other treatment or diagnostic testing were rendered. The doctor even goes so far as to opine that "THIS IS NOT AN EMERGENCY MEDICAL CONDITION."

   Be that as it may, the doctor could not have assessed all that prior to performing the evaluation. The rule is not intended to punish providers that perform evaluations resulting in negative findings.

   The question is not whether the patient's health or bodily functions were in *actual* jeopardy or danger of dysfunction. Rather, if the evidence supports the absence of immediate medical attention could reasonably be expected to result in jeopardy to health or bodily function or serious dysfunction of an organ or part, then the situation is an emergency under the rule. Review of the triage record finds such an expectation is supported.

   Based on the record up to that point, the doctor was justified in assessing the patient. The patient had presented with intense pain to the emergency room, and the triage nurse documents severe pain rated as 9 out of 10 on the pain scale. This symptom by itself meets the definition of severe pain sufficient to support an emergency as defined in Rule §133.2(5)(A). Regardless of the doctor's findings after performing the assessment, the triage nurse documented an emergency sufficient to support the doctor's performing the assessment.

   The existence of an emergency is an exception to the requirement that the treating physician direct care. It is also an exception to any preauthorization requirements under Rule §134.600(c)(1). The insurance carrier did not challenge the medical necessity or relatedness of the services to the employee's injury. Accordingly, the services are eligible for review.

   The division concludes the respondent has failed to support denial of payment based on lack of emergency.

3. Additionally, the insurance carrier denied the disputed services with claim adjustment reason codes:

   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

   Review of the submitted information finds that these denial reasons are not supported. The respondent did not identify what information was necessary or lacking or describe any bill submission errors sufficient to support denial of payment. More importantly, the insurance carrier did not request any additional information or specify the lacking information or bill submission errors to the health care provider prior to the filing of the request for MFDR. Review of the documentation finds that it supports the service billed. The insurance carrier's denial reasons are not supported. Accordingly, the disputed service is eligible for review of payment.

4. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83.

   (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors. . .

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2016 is $56.82.

5. Procedure code 99283, June 16, 2016, represents an emergency room evaluation and management service. Reimbursement is calculated by multiplying the relative value (RVU) for work of 1.34 by the geographic practice cost index (GPCI) for work of 1, resulting in 1.34. The practice expense (PE) RVU of 0.29 multiplied by the PE GPCI of 0.92 is 0.2668. The malpractice RVU of 0.12 multiplied by the malpractice GPCI of 0.822 is 0.09864. The sum of 1.70544 is multiplied by the division conversion factor of $56.82 for a MAR of $96.90.

6. The total allowable reimbursement for the services in dispute is $96.90. The insurance carrier has paid $0.00. The amount due to the requestor is $96.90.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $96.90.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $96.90, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.